rupture of the ureter the contrast material should not appear around calyces, which is usually the case with forniceal rupture (Ginsberg 1965). Further, the patient is usually much more unwell, with a high temperature and leukocytosis. It is not uncommon to confuse this condition with other acute abdominal emergencies. Retroperitoneal sepsis is a common complication, and 3 deaths have been reported (Berry 1921, Geisinger 1931) in association with rupture of the ureter due to retroperitoneal sepsis.

The treatment of choice is open drainage of the retroperitoneal space with an attempt to remove the stone if found. Should a stone be found in the lower ureter with a tear proximal to it, either in the ureter or renal pelvis, endoscopic extraction of this stone with the Dormia basket is sufficient, without the need for open drainage. The latter treatment was successful in our patient and has not been described previously. Antibiotic cover is mandatory.

The cause of rupture of the ureter could be explained on the basis of either stone impaction causing pressure necrosis or, as the stone is passing in the ureter, it may traumatize the ureter; in either case, when the intraureteric pressure increases during an attack on renal colic, the damaged tissue may give way.

This case presented several additional interesting features. The stone was found to be distal to the site of the leak. The ureter proximal to the stone was not dilated, a feature noted in 2 cases reported by Weaver (1980). It may be that the escape of urine through the renal vent allows the intraureteric pressure to remain unchanged, with no proximal dilatation of the ureter.

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## Phimosis of the prepuce of the clitoris: indication for female circumcision[1]

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A case of phimosis of the hood of the clitoris in a postpubertal female is presented. This has not been reported previously. The patient was treated by operation analogous to circumcision in the male.

*Case report*

A 24-year-old, white, married nullipara presented in December 1982 with a three-month history of anterior vulval swelling. There was no pain but discomfort prevented her wearing trousers, and dyspareunia had been present for the same length of time. She had had an intermittently malodorous, yellow vaginal discharge for three months, but there was no pruritus, and this had been treated with clotrimazole by her general practitioner.

Diabetes had been diagnosed at the age of 13. She had been taking insulin zinc suspension (Hypurin Lente) 28 units daily but had made no attempt to monitor blood or urine sugar for two years.

On examination she was found to be fit with normal pelvic viscera. There was a 2 cm soft cystic swelling of the prepuce of the clitoris, which was not inflamed (Figure 1). Her fasting blood glucose was 15.8 mmol/l. After stabilizing her diabetes on Mixtard (20 units daily, 16 units nightly), examination under anaesthesia revealed the preputial stoma which was dilated with silver probes and a dorsal slit made to the apex of the prepuce. The flaps so formed were trimmed to blend with the labia minora. Microbiological cultures from vagina and clitoris grew no pathogens.

Her postoperative recovery was uncomplicated. When seen one month postoperatively, she was able to wear trousers and vulval anatomy appeared normal.

*Discussion*

Benign enlargement of the clitoris associated with antenatal exposure to exogenous or endogenous androgens is a well recognized condition (Grumbach *et al.* 1959).

Tumours of the clitoris are rare but several have been reported: neurofibromata (Schepel & Tolhurst 1981), haemangioma (Kaufman-Friedman 1978), adenocarcinoma (Piver & Xynes 1977), malignant melanoma (Chung *et al.* 1975),

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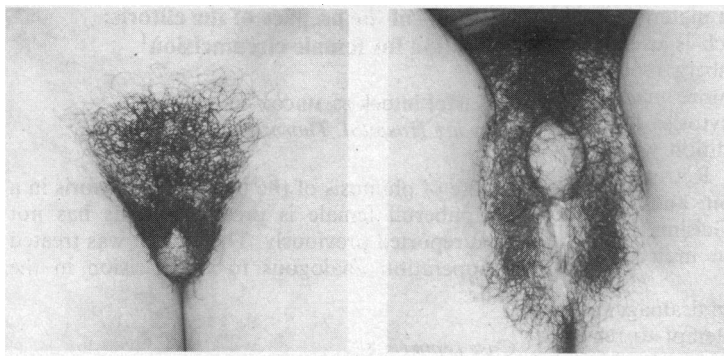

Figure 1. Preputial retention cyst

leiomyosarcoma (Yang *et al.* 1965). Secondary spread has been described from stomach (Ahmed & Beasley 1979) and from bladder (Powell & Jones 1983).

Phimosis of the prepuce of the clitoris has seldom been reported (Kramarosky & Manriquez 1975), but has not been reported in the post-pubertal female. It may be, however, that this is a condition which will be seen more frequently in association with the wearing of tight trousers by young women.

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# Unusual presentation of Meckel's diverticulum[1]

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A case is reported of an unexplained iron deficiency anaemia which later presented with rectal bleeding due to a giant, impacted, pelvic, Meckel's diverticular enterolith causing an ileorectal fistula, an association which has not previously been reported.

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*Case report*

A 14-year-old boy was referred for investigation of a three-month history of lethargy and malaise. There was no history of abdominal pain, rectal bleeding or melaena. He was found to have an iron deficiency anaemia, but stool examination was negative for occult blood on several occasions. His symptoms improved after a prolonged course of treatment with oral iron, and was not investigated further at this stage.

Three years later he presented again with a three-month history of watery diarrhoea and an episode of rectal bleeding. Barium enema revealed no cause for bleeding but a faintly opacified concentrically laminated mass was noted in the pelvis (Figure 1). His symptoms improved and he declined further investigation.

Two years later he was referred with further watery diarrhoea but no rectal bleeding. A barium

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